THE CANCER LETTER INTERACTIVE

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# NCI Advisors Approve Plan For Repository For Prostate Cancer Tissue Specimens

NCI advisors last week approved the Institute's plan to fund a National Prostate Cancer Repository to make tissue specimens and data available to prostate cancer researchers.

The NCI Board of Scientific Advisors approved the concept statement for the repository at its March 8 meeting. The Institute plans to fund three to five cooperative agreement awards, worth about $11.1 million over five years, to institutions that would develop a "virtual" resource in

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*In Brief:*

## Nabel To Direct Vaccine Research Center; Former NIH Director Robert Marston Is Dead

**GARY NABEL** was appointed director of the Vaccine Research Center at NIH last week. Nabel is the Henry Sewall professor of internal medicine and professor of biological chemistry at University of Michigan in Ann Arbor and a Howard Hughes Medical Institute Investigator. The VRC, a project within the NIH intramural research program funded by NCI and the National Institute of Allergy and Infectious Diseases, was formed to develop candidate vaccines against HIV. "Gary Nabel is a superb scientist who has excelled at the frontiers of virology, immunology, gene therapy and molecular biology," NIH Director **Harold Varmus** said in an official statement. "As a result of his experiences with clinical and laboratory research in academia and extensive interactions with industrial partners, he is remarkably well prepared to lead the complex, multidisciplinary and collaborative activities that will be required to develop an effective HIV vaccine. His recent work—on novel strategies for gene therapy for AIDS and for vaccines against cancer and Ebola virus—illustrates the imagination and drive that he will bring to the NIH Vaccine Research Center." Construction of a five-story facility on the NIH campus, which began in August 1998, is expected to be completed by mid-2000. When the VRC is fully operational, Nabel will oversee about 100 scientists and support staff, NIH said. **President Clinton** said in an official statement, "I have issued a challenge to the scientific community to find an AIDS vaccine within the decade. We are making important strides towards that critical goal and the leadership of Dr. Nabel will help us progress even more." . . . **ROBERT MARSTON**, director of NIH from 1968 to 1973 and president of the University of Florida from 1974 to 1984, died March 14 of cancer at the Hospice of North Central Florida in

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# BSA Approves Plan To Fund Prostate Cancer Repository

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which the specimens would remain at each institution, but the data would be collected in a centralized database.

The development of a prostate cancer repository was one of the recommendations of the Prostate Cancer Progress Review Group (**The Cancer Letter**, Feb. 26). The PRG report is available on the NCI website at http://wwwosp.nci.nih.gov/planning/prg/default.htm

Other NCI funding opportunities in prostate cancer are listed at http://www.nci.nih.gov/prostate.html

The excerpted text of the concept statement follows:

**Cooperative Prostate Cancer Tissue Resource**. Concept for a new RFA (cooperative agreements), first-year set-aside $1.5 million, total cost $11.1 million over five years, three to five awards. Program director: Jules Berman, Division of Cancer Treatment and Diagnosis.

The purpose of the concept is to request applications institutions interested in developing a National Prostate Cancer Repository to make tissue specimens and data available to support prostate cancer research. It is anticipated that three to five institutions would receive funding for a period of five years to develop a virtual resource. A virtual resource is one in which the specimens remain at the institution where they were collected while the data is centralized in a single database. Initially archival formalin-fixed, paraffin-embedded tissue blocks will be accrued. A prospective collection of frozen tissue specimens would be initiated in year 2 to meet future needs and changing technology. Specific advantages of a national prostate repository include:

—Large numbers of specimens could be made available to permit studies on large patient populations and to create opportunities for hypothesis testing, translational studies, and diagnostic validation studies that would otherwise be difficult to carry out.

—Quality control standards for prostate specimen collection would be established and maintained, and a robust repository informatics systems would be developed to facilitate collection of clinical information.

The repository would be designed to accrue large numbers of prostate cancer cases with archival tissue blocks representative of the patient diagnosis, nodal metastatic tissue blocks and normal adjacent prostate tissue, as well as the clinical information related to those cases. Multiple awards will be required to create the virtual tissue resource with a central database. Tissues and associated clinical information will be available to researchers, prioritized by the results of an outside review of their requests by a scientific review committee. Applicants should propose methods to assemble tissues and data into a useful and accessible form. They must also demonstrate that they can maintain patient confidentiality and conform to current and future ethical and legal guidelines for the collection and distribution of human tissues for research. All applicants must propose the establishment of a paraffin tissue archive and development of a database with demographic, histopathological, clinical and outcome data for each case. The paraffin tissue archive will be suitable for morphologic, immunohistochemical and some molecular biologic studies, particularly those that involve DNA. Applicants must also agree to cooperate with other resource participants to make tissues available for research. A coordinating committee with representatives from each of the participating institutions and an NCI representative will oversee the operation of the resource.

**A second concept** presented to the board titled, "National Network for Research on Causes of Cancer in Children," was withdrawn by NCI after board members expressed opposition to the proposal. The concept proposed a five-year, $14.8 million grant to a single awardee to establish a central registry of cancer cases in children and a tissue bank.

NCI officials said the concept was developed in response to a Presidential Executive Order that directed federal agencies to take steps to protect

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children from environmental hazards.

BSA member Louise Strong, professor in the Department of Experimental Pediatrics and Medical Genetics, University of Texas M.D. Anderson Cancer Center, said it was not clear what the proposed network could offer that is not already available through other NCI-funded resources.

"It's hard to say anything negative about motherhood and apple pie, but I had a lot of concerns," Strong said. "We've got a lot of resources out there in terms of studies of childhood tumors," including four cooperative groups (soon to merge).

"What is really the unique niche that this would fund?" Strong asked. "I'm concerned that in setting up a new network, we could end up competing with or undoing existing systems that work very well."

BSA member Joseph Simone, medical director, Huntsman Cancer Foundation and Institute, University of Utah, agreed. "Executive orders are bad science," he said.

"If this were to be carried off, the tissue bank to be created would be a wonderful use to an investigator who wishes to know why children get one cancer and not another," said BSA member William Wood, professor and chairman of surgery, Emory University School of Medicine. "But if one wished to address the question of why children get cancer, it would be enormously important to have a control tissue bank. I've heard no mention of such tissue-gathering."

Robert Wittes, NCI deputy director for extramural science, withdrew the concept.

Discussing the prostate cancer repository concept, BSA member Frederick Appelbaum said, "I liked Louise's comment about the childhood cancer concept being motherhood and apple pie. This one is fatherhood and Metamusil. I'm strongly in favor of it. This one comes from the people who actually work in prostate cancer, the Prostate Cancer Progress Review Group, and I think this is essentially a no-brainer."

Appelbaum suggested adding a method to validate the use of the repository by researchers. He asked how NCI developed the budget estimate for the project.

Roger Aamodt, chief of the Resources Development Branch in the Cancer Diagnosis Program, said the budget was based on the Institute's previous experience with tissue resources.

The board voted unanimously to approve the concept.

*Science Policy:*

## NCAB Opposes Law Making Data Available Under FOIA

The National Cancer Advisory Board passed a resolution urging the repeal of a law that makes grantee research data available under the Freedom of Information Act.

The board also sent a letter to the White House Office of Management and Budget seeking an extension of the public comment period for a proposed rule that would implement the new law.

The provision, drafted by Sen. Richard Shelby (R-AL) and included in last fall's budget law, makes all federally-funded research subject to FOIA.

In a Notice of Proposed Rulemaking, the OMB sought to narrow the scope of the law, limiting it to material that is used as a basis for federal regulations and published research. The notice, in the Feb. 4 Federal Register, is available on web at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=1999_register&docid=99-2220-filed

NCI said the new law would have implications for most of its extramural research programs. "Since many policy decisions made by agencies such as the Health Care Financing Administration, Social Security Administration, Environmental Protection Agency, Food and Drug Administration draw upon findings from NCI sponsored research, most NCI extramural awards might be affected by this new law," the NCI statement said.

The NCI statement (http://www.nci.nih.gov) did not propose a position on the law, but encouraged researchers to send comments to OMB.

NIH, in a statement on the OMB proposed rule, listed a series of questions that illustrate the potential scope of the new law and point out the difficulties for researchers in complying with it. The law does not define "data," or state at what point data would have to be released. It is also not clear whether the privacy of individual research subjects is fully protected.

"This legislation has significant implications for the conduct of research and the protection of research data as well as for the sharing of research data," the NIH statement said. "While the NIH supports the sharing of research data, it is important that such sharing take place in the context of well-developed policies and procedures to address the many questions that may arise."

The NIH statement is available at http://www.nih.gov/grants/policy/a110implications.htm

Rep. George Brown (D-CA), the ranking Democrat on the House Science Committee, introduced legislation to repeal the provision.

Many scientific and professional societies have submitted comments, including the American Association of University Professors (http://www.aaup.org/omb.htm ).

Comments on the OMB notice should be addressed to: F. James Charney, Policy Analyst, Office of Management and Budget, Room 6025, New Executive Office Building, Washington, DC 20503. When possible, comments should be provided in a word processing file on a computer disk or e-mailed to fcharney@omb.eop.gov as full text with the message (not as an attachment). The sender's name, title, organization, postal address, and e-mail address should be included in the text of the message.

Comments are due by April 5.

**The text of the NCAB resolution follows:**

Whereas, progress in biomedical research depends on the free and open exchange of information; and

Whereas, the National Cancer Advisory Board recognizes that awardees have an obligation to promptly inform the public of the outcomes and make available the underlying data resulting from publicly funded research; and

Whereas, the revisions to OMB Circular A-110 ordered by the Omnibus Supplemental Appropriations Act (Public Law 105-277) making research data generated from publicly supported awards available under the Freedom of Information Act could be damaging to scientific research by negatively affecting voluntary participation of human subjects, compromising the confidentiality of medical information, causing premature disclosure of incomplete and possibly contradictory data, and undermining protections for intellectual property rights; and

Whereas, the NCAB is aware that data comes in many forms and can be generated under many different situations, including: data contributed to a project by the investigator; data provided to a project from another non-federal source; and data created by public/private collaborative studies making it impossible to determine the "ownership" of; and

Whereas, the NCAB finds that the costs of compliance and time and effort associated with the statutory language could be significant, and individual agencies, institutions and researchers are not currently reimbursed for costs associated with compliance; and

Whereas, the collective reservations engendered in investigators by this rule is almost certain to have as an unintended consequence an increasing reluctance to participate in government sponsored research, and to deter young scientists from choosing careers in academic institutions dependent on federal research support;

Be it, therefore, resolved that the National Cancer Advisory Board calls upon national legislators, health professionals and scientists to support rescission of the revisions to the OMB Circular A-110 ordered by Public Law 105-277; and

Furthermore, be it resolved that the NCAB supports proposing an amendment to the OMB Circular A-110 to allow individual agencies, institutions and researchers to retain fees from requestors equaling the full incremental costs of obtaining data responsive to FOIA requests.

*Capitol Hill:*

## Trials Results Represent Culmination Of Research, Klausner Tells Appropriators

Clinical trials results announced over the past year demonstrate the ability of the National Cancer Program to develop methods for cancer prevention and treatment, NCI Director Richard Klausner said to the House subcommittee that appropriates funds for the Institute.

"This has been a year of real progress in cancer research," Klausner said to the House Labor, HHS, and Education Appropriations Subcommittee at its Feb. 24 hearing on the fiscal year 2000 budget. "In many ways, these trials are the culmination of the research pipeline. They establish the real value of innovation and change the practice of medicine to benefit people with or at risk for cancer."

In previous appearances before the subcommittee, Klausner has discussed scientific opportunities. This year, he decided to emphasize clinical research, he said.

"One of the goals of this year's discussion was to answer questions raised by many members [of Congress] about how we are handling the large increases [in appropriations], and particularly how we are handling the 15 percent increase from last year," Klausner said last week to the NCI Board of Scientific Advisors. "There was an interest in how all the exciting science that we talk to the committees about are linked to the betterment of people."

"This year, I chose to begin not with the underlying science, but with this issue of near-term answers," he said.

**"A Year Of Real Progress"**

*The text of Klausner's written testimony to*

*the House subcommittee follows:*

This has been a year of real progress in cancer research. For the past three years in appearing before you, I have emphasized the dramatic changes in the science and technology of cancer research, changes that we at the National Cancer Institute are fostering and facilitating. We are all convinced that these changes can and will be applied to reducing the burden of cancer and that they will accelerate the continuing reduction in cancer incidence and mortality that we first reported two years ago.

This year, I would like to illustrate some of the tangible advances made just over the past year in the prevention and treatment of specific cancers. Of course, this only represents a fraction of what we do in order to understand the causes and nature of cancer. It is fitting to report on clinical trials results in this, the 50th anniversary of the introduction of the modern, randomized controlled trial. In many ways, these trials are the culmination of the research pipeline. They establish the real value of innovation and change the practice of medicine to benefit people with or at risk for cancer. Let me highlight a few examples which illustrate several important themes. First, we are beginning to approach the prevention of cancer in addition to its treatment. Second, we are continuously optimizing even our conventional therapies in order to improve patient outcome. Third, we are beginning to tailor therapy to more precise diagnostic categories of cancer, which is made possible by a new age of molecular diagnostics. Fourth, we have begun to test novel therapies targeting the molecular machinery of cancer, heralding the future of cancer prevention and treatment.

This year, we reported the successful results of the first major cancer prevention trial carried out by one of the NCI-funded clinical trials groups, NSABP. It is an example of a mechanism-based intervention aimed at preventing this common cancer. By treating women who have elevated risk for breast cancer with a partial estrogen antagonist, tamoxifen, a 50 percent reduction in incidence of breast cancer was observed over the course of the study. There was a 70 percent reduction in breast cancer incidence for those breast cancers expressing estrogen receptors, whereas there was no change in incidence of breast cancers that lacked this receptor which is the molecular target for the drug. This study showed that we can reduce the risk of breast cancer. Much remains to be studied and tamoxifen is far from perfect in terms of its effectiveness and its side effects. It is, however, an important and landmark beginning.

The optimization of existing therapies continues to be an important approach to improving the outcome for cancer patients. Years of clinical trials to optimize chemotherapy regimens for children with acute lymphocytic leukemia (ALL) have resulted in a current cure rate of 75-80 percent. About 20 percent of children with ALL have poor prognostic characteristics and a much bleaker outcome. Results of a new trial using a modified chemotherapy regimen has resulted in a 70 percent drop in the rate of treatment failures in these high risk children under 10 years of age; these children have a 5-year event-free survival of 84percent with this new regimen.

Nasopharyngeal cancer is relatively rare in the United States but quite common in Asia. Chinese American men have a 15-20 fold higher rate of this cancer than white American men. While nasopharyngeal cancer has been known to be responsive to radiotherapy or chemotherapy, a trial comparing the former to a combination of radiotherapy plus Cis-Platin + 5-FU was stopped early because of profound benefit. The three-year survival in the radiotherapy alone group was 47 percent, whereas, the combined group had a 78 percent three-year survival, and a 60 percent reduction in mortality.

**Differential Response to Therapy**

Why some patients respond to a given therapy and others, with ostensibly the same disease, do not, is a central puzzle we are beginning to solve. One likely explanation is that the responders actually have a different disease than the non-responders. In a recently reported series of studies, one explanation for outcome differences in breast cancer has apparently emerged. About 30percent of breast cancers make too much of a protein called, HER2/neu. These cancers appear to be more aggressive and new studies showed that these cancers respond significantly better to elevated doses of anthracycline drugs than cancers that don't over-express this protein. This conclusion came from the analysis of several breast cancer treatment trials that were not originally designed to answer the question about the role of HER2 in the response to therapy. These subsequent analyses were done in order to explain why some women responded better to higher doses of therapy while others did not. Critical studies such as these require that scientists who have new ideas and new technologies have access to tissue samples that are linked to important clinical data. Over the past year, we have created a new approach to funding more of these important correlative studies and have developed a new set of mechanisms to expedite interactions between researchers with good ideas and researchers with access to tissue banks.

One of the ultimate goals of cancer research is to uncover the molecular machinery of each cancer in order to target prevention and therapies to that machinery. The great hope is that such targeted approaches will prove to be both more effective and less toxic than our current approaches. This past year, based upon clinical trials results, the FDA approved the first two monoclonal antibodies, Herceptin and Rituximab, for the treatment of cancer. Each is directed at a molecule expressed on the surface of specific types of human cancer.

Herceptin is directed against HER2, a protein discovered almost 20 years ago, and proposed as a potential therapeutic target almost 15 years ago. This new

drug was tested this year against metastatic breast cancer, the most deadly and least treatable stage of this disease. When such patients are treated with the drug Taxol, only 16 percent experience a clinical response of tumor shrinkage. However, with the addition of Herceptin, 42 percent of patients have anti-tumor responses and these women experience a statistically significant prolongation of survival. As hoped for, Herceptin added relatively little toxicity. Now, we are working with the company that developed Herceptin to rapidly expand the evaluation of this agent in earlier stages of breast cancer and in the treatment of other cancers, such as ovarian, which over-express the target of this drug.

Non-Hodgkin's lymphoma is newly diagnosed each year in over 55,000 Americans. It is one of the few cancers whose incidence has been rising. Fifty percent of those diagnosed will die of their disease and, as with so many cancers, we need new, more effective and less toxic therapies. Twenty years ago, basic immunologic research identified a molecule, CD20, specific to the surface of B lymphocytes which was also highly expressed on the surface of most lymphomas. An antibody directed against this molecule was shown to be able to kill cells and thus began a 15-year odyssey to engineer an anti-CD20 antibody which could be used in treatment. Last year, such an engineered antibody, Rituximab, was approved by the FDA. It is becoming the treatment of choice for patients with low grade lymphoma. It is as effective at inducing remission as chemotherapy but with very little toxicity. As with all such advances, we do not stop there but use these findings as a stepping stone for further development. Multiple clinical trials are underway to broaden the cancer targets for Rituximab, to combine it with chemotherapy and, in a very promising development, to arm the antibody with radionuclides. Early phase II studies with $I^{131}$ -labelled anti-CD20 show it to be five times more effective at inducing long-term disease-free survival than the best available chemotherapy. These promising results will need to be validated in definitive clinical trials with the hope that this new example of molecular therapy will profoundly alter the outlook for these cancer patients.

These examples are just a sampling of recent clinical trials culminations. Our clinical trials not only examine new treatment regimens but also evaluate ways of reducing toxicity, decreasing pain and suffering and improving the short and long-term quality of life for cancer survivors.

We are now instituting the first major reform and restructuring of the NCI national clinical trials system since it was established 40 years ago. The goal of this restructuring is to make this national resource function even better by:

1. creating a new peer review system that will allow and encourage any scientist to propose the best ideas for large-scale clinical trials,

2. providing a complete menu of clinical trials options that will be available to all patients and all participating physicians,

3. improving the operating characteristics of the clinical trials system, reducing barriers to participation, speeding the conduct of the trials and enhancing the efficiency and effectiveness of these important studies,

4. moving to adequately fund this research system,

5. improving our communication processes to provide everyone with comprehensible information about clinical trials.

These changes will mean more clinical trials culminations over the next several years. This fiscal year, we have provided a 30percent increase in funding to our national clinical trials system to enable these changes. Among other changes, this will allow us to increase the number of new trials initiated and to address more questions within all of our trials.

We have also restructured our clinical trials capabilities within our intramural research program. This coming year, we intend to initiate definitive clinical trials to test the benefit of novel vaccine therapies directed against non-Hodgkin's lymphoma and melanoma, the two major cancers whose incidences are rising in the U.S.

Clinical trials are the culminations of the research pipeline that must be filled, if we are to build on the progress made to date.

**Improving Cancer Detection**

Two years ago, we set up the Cancer Genome Anatomy Project (CGAP) to systematically identify the gene expression patterns that characterize human cancer. It is time now to begin to apply the gratifying progress of this project in order to develop new molecular classification schemes for patients with cancer. If successful, this will fundamentally change our approach to diagnosis, to the choice of therapy and to our ability to predict patient outcome. The Director's Challenge is a $50 million program to challenge the scientific community to accomplish just that and to deliver a new generation of diagnostic and prognostic practices to patients with cancer.

We are anxious to realize the dream of having sensitive and accurate tests to detect cancer early when it is most curable. CGAP has enabled the discovery of literally hundreds of potential markers for cancer over the past two years. For example, one year ago, we knew of no potential unique marker for ovarian cancer. Today, CGAP has provided 400 candidates ready to be tested. With the new funds we received this year, we are establishing the Early Detection Research Network to, for the first time, create a national research infrastructure to rapidly develop and test such potential markers for cancer. We are hoping that such tests will give us accurate, predictive and simple blood tests for all types of cancers.

The ability to detect, diagnose and evaluate cancer by imaging is a critical part of our approach to these diseases. We have never had a rapid way to evaluate the constantly changing technologies within the context of

clinical trials. To remedy that, this year, we established the diagnostic imaging research network. This network will begin by addressing important clinical questions, such as defining the role of CT scanning and magnetic resonance imaging in the staging of women with cervical cancer.

There is a great need to assure that we fill and expand the pipeline of new agents for the prevention and treatment of cancer. This past year, we initiated a new program called RAID (for Rapid Access to Interventional Development) in order to fund the rapid transition of new therapeutic reagents from the laboratory to the clinic after rigorous peer review in order to identify the most promising proposals. In its first year, RAID will fund 20-30 new therapeutics for such rapid development. Due to its initial success, we hope to be able to expand RAID and are also adding a new program called RAPID to offer the same process for agents aimed at preventing cancer.

Progress against cancer takes place through both the development of knowledge and of new technologies. New technology often enables the discovery of new knowledge as well as the application of that knowledge to people with, or at risk for, cancer. Evaluating, reviewing and funding research aimed at acquiring new knowledge requires different approaches than for technology development. For these reasons, this year, we created a new grant mechanism called the Phased Innovation Award which is already proving to be a highly sought after award tailored to technology development.

**New Efforts in 1999**

New resources over this past year has enabled us to initiate a wide range of new research programs and projects. These include new programs in tobacco-related research, initiatives in basic biobehavioral and health communications research and a variety of programs aimed at more rapidly translating basic discoveries to clinical testing in prevention, detection, diagnosis and treatment.

The progress we are making in cancer research does not equally reach all Americans. Minorities and the underserved often have higher incidence and mortality rates and poorer outcomes. The NCI supports an extensive research program aimed at identifying and explaining the unequal burden of cancer in our diverse society. This year, we will expand our support of cancer control and research infrastructures in minority and underserved communities as one component of addressing the unequal cancer burden.

We have improved and enlarged our programs to monitor cancer burden and to identify environmental factors that may contribute to that burden. This year, we will publish, for the second time, a 25-year survey of cancer mortality rates, cancer-by-cancer, for all 3,000 U.S. counties. This will serve as the basis for our ongoing search for clues to environmental, regional and occupational causes of cancer.

A two-year strategic effort to redesign our training and career development programs aimed especially at strengthening clinical research, multi-disciplinary training and training opportunities for minorities and the underserved, has begun to be implemented with a 30 percent increase in dollars aimed at training and career development in FY99 over FY98.

Our Cancer Centers Program which was redesigned two years ago, has grown to include five new centers in parts of the country which had not had NCI-designated cancer centers over the past two years and we expect to fund two to four new centers in the current year.

Finally, a 15 percent increase in dollars in the 1999 research projects grants pool is enabling us to fund approximately 400 additional projects and a total of 1,229 competing grants this year, including our AIDS research program.

This year, the President has proposed a 2.4 percent increase in the NCI cancer budget to $2,732,795,000. This will allow us to continue to support the many initiatives that I have outlined for you. Funds for AIDS research are included with the request of the Office of AIDS Research.

## Mack Calls Budget Proposal "Formal Act Of Retreat"

Sen. Connie Mack (R-FL) said the 2 percent increase the Adminstration proposed for NIH "will clearly undercut our researchers' ability to improve the quality of life for all Americans."

Mack, co-chair of the Senate Cancer Coalition, addressed a March 16 Capitol Hill event sponsored by NIHx2, an organization set up last year to lobby for doubling the NIH budget by the year 2003. The effort has the support of 300 organizations, including the Ad Hoc Group for Medical Research Funding, the Campaign for Medical Research, the National Health Council and Research! America.

"I am extremely disappointed in the President's budget request for medical research funding," Mack said. "It is a formal act of retreat in the heat of battle."

The Senate and House budget committees are considering lifting the budgetary "caps" that would make it possible to increase the allocations.

Mack recently announced that he would not run for re-election when his term expires next year.

*Funding Opportunities:*

## NCI Lists Funding Initiatives For Breast Cancer Research

NCI has issued a list of its funding initiatives for breast cancer research in response to the report of the Breast Cancer Progress Review Group (**The Cancer Letter**, Feb. 26).

The list of funding initiatives is available on the NCI website at http://www.nci.nih.gov/bci.html

The report of the Breast Cancer Progress Review Group, "Charting the Course: Priorities for Breast Cancer Research," is available at http://wwwosp.nci.nih.gov/planning/prg/bprgtableofcontents.htm

"NCI expects to use a portion of its grant funds to support high-priority applications relevant to breast cancer," according to the NCI statement. "We plan to give special attention to applications that address high-priority gap areas as defined by the Breast Cancer PRG, particularly those that fall within the areas of extraordinary opportunity in the Bypass Budget but fail to meet the established payline. Applicants submitting such grant proposals should reference the Breast Cancer PRG Report, whenever appropriate, in the cover letter accompanying their submission."

Decisions on funding individual grants as exceptions occur three times per year. Further information on NCI grants funding is available from the NCI Division of Extramural Activities website at http://deainfo.nci.nih.gov/

## RFA Available

**RFA CA-99-005: Technologies For Generation Of Full-Length Mammalian cDNA**

Letter of Intent Receipt Date: April 6

Application Receipt Date: May 13

In an effort to provide the research community with high quality, full-length mammalian cDNA clones and sequences, NIH has established the Full-Length cDNA Initiative, managed by a trans-NIH steering committee. The purpose of this RFA is to support the development of technologies that will facilitate the generation of a complete set of full-length human cDNAs as well as other mammalian cDNAs. This RFA is intended to support innovative research projects aimed at solving one or more of the problems currently associated with the production of a complete set of full-length human cDNA clones and full-length cDNA clones from other mammals.

Investigators may propose small, high-risk pilot projects, requiring budgets of up to $100,000 direct costs per year for two years using the R21 funding mechanism or they may propose larger research projects of up to three years using the R01 funding mechanism. The participating Institutes and Centers intend to commit $2 million (total costs per year) to fund approximately 10 awards.

Inquiries: Jennifer Couch, Ph.D., Division of Cancer Treatment and Diagnosis, NCI, 6130 Executive Blvd Room 700, Bethesda, MD 20892, phone 301-402-4185, fax 301-402 7819, email: jc332a@nih.gov

## NCI RFP Available

**RFP N01-CP-91024-21: Radiation Dosimetry For Epidemiologic Studies**

Deadline: Approximately May 7

The NCI Radiation Epidemiology Branch of the Division of Cancer Epidemiology and Genetics Program, is recompeting a requirement to continue dosimetry support for epidemiologic studies of populations exposed to ionizing radiation, conducted by the REB. This contract (Number N01-CP-40535) with the University of Texas M.D. Anderson Cancer Center, is scheduled to expire September 24, 1999. This support is essential to REB's ability to quantify radiation risks and provide information on dose-response relationships.

Inquiries: Barbara A. Shadrick; email: bs92y@nih.gov fax 301-480-0241. The RFP may be accessed through the Research Contracts Branch at http://rcb.nci.nih.gov/rfp.htm

*In Brief:*

## Philip Strax, 90, Radiologist, Mammography Advocate

(Continued from page 1)

Gainesville, university officials said. He was 76. Marston served as chairman of the Safety Advisory Committee following the Three Mile Island nuclear plant accident. He co-edited a book, "Medical Effects of Nuclear War," for the National Academy of Sciences. The University of Florida plans to hold a public memorial in April. A private burial will be in Tappahannock, VA. . . . **PHILIP STRAX**, a radiologist and early advocate of breast cancer screening using mammography, died March 9 in Bethesda, MD. He was 90. Strax collaborated on the Health Insurance Plan of New York randomized controlled trial of mammography for breast cancer screening. He opened three clinics for breast cancer detection, including the Guttman Institute in New York, now owned by Memorial Sloan-Kettering Cancer Center. He authored several books about breast cancer, as well as three volumes of poetry. . . **UNIVERSITY OF PENNSYLVANIA** Cancer Center has recruited two faculty members to expand the department of Radiation Oncology. **Paul Wallner** was named clinical professor and vice chair, and **Robert Lustig** was appointed clinical professor and associate chair for clinical research. Wallner was chief of radiation oncology at Robert Wood Johnson Medical School in Camden, NJ. Lustig was clinical director of radiation oncology at Cooper Hospital/University Medical Center.

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